BOGOTA CHIROPRACTIC & HOLISTIC CENTER
NEW PATIENT FORM

Section 1 - Patient Demographics:		
First Name:	**Middle:**	**Last Name:**
Date of Birth: / /	**Age:**	**Gender (circle): M / F**
Address:		
City:	**State:**	**Zip:**
Preferred Phone:		**Secondary Phone:**
Email Address:		
Referred By:		
Occupation:		
Height:	**Weight:**	

Section 2 – Present Health and/or Nutritional Concerns:
What health and/or nutrition concerns would you like to focus on during your visit?
#1
#2
#3
#4

Section 3 - Medical History:					
Please check "YES" for the health conditions your doctor has diagnosed, and record the approximate date of onset.					
GASTROINTESTINAL			**INFLAMMATORY/AUTOIMMUNE**		
Condition	**Yes**	**Date Onset**	**Condition**	**Yes**	**Date Onset**
Irritable Bowel Syndrome (IBS)			Chronic Fatigue Syndrome		
Inflammatory Bowel Syndrome			Rheumatoid Arthritis		
Crohn's Disease			Lupus / S.L.E.		
Constipation			Frequent Infections		
Ulcerative Colitis			Severe Infectious Disease		

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Celiac Disease			Herpes		
Gastric/Peptic Ulcer Disease			Gout		
GERD, Reflux/Heartburn			Polymyalgia Rheumatica		
Hepatitis C or Liver Disease			Other:		
Food Intolerance					
Other:					

RESPIRATORY			**MUSCULOSKELETAL / PAIN**		
Condition	**Yes**	**Date Onset**	**Condition**	**Yes**	**Date Onset**
Asthma			Osteoarthritis		
Chronic Sinusitis			Chronic Pain		
Sleep Apnea			Fibromyalgia		
Bronchitis/Emphysema			Migraine Headaches		
Tuberculosis			Other:		
Other:					

CARDIOVASCULAR			**URINARY / REPRODUCTIVE**		
Condition	**Yes**	**Date Onset**	**Condition**	**Yes**	**Date Onset**
Heart Disease / Heart Attack			Kidney Stones		
Stroke			Urinary Tract Infections		
Elevated Cholesterol			Yeast Infection		
Irregular Heart Rate			Prostate Problems		
High Blood Pressure			Erectile Dysfunction		
Other:			Painful Intercourse		
			Endometriosis		
			Other:		

NEUROLOGICAL / BRAIN			**METABOLIC / ENDOCRINE**		
Condition	**Yes**	**Date Onset**	**Condition**	**Yes**	**Date Onset**
Depression			Type I or II Diabetes		
Anxiety			Metabolic Syndrome (X)		

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NEUROLOGICAL / BRAIN			METABOLIC / ENDOCRINE		
Condition	**Yes**	**Date Onset**	**Condition**	**Yes**	**Date Onset**
Bipolar Disorder			Hypoglycemia		
ADD/ADHD			Hypo/Hyperthyroidism		
Multiple Sclerosis			Polycystic Ovarian Syndrome (PCOS)		
Seizures			Infertility		
Anorexia Nervosa			Other:		
Bulimia					
Unspecified Eating Disorder					
Parkinson's Disease					
Alzheimer's					
Other:					

DERMATOLOGICAL			CANCER: Please list type(s) and treatments		
Condition	**Yes**	**Date Onset**	**Condition**	**Yes**	**Date Onset**
Eczema			1: Type:		
Psoriasis			Treatment:		
Acne			2: Type:		
Other:			Treatment:		
			3: Type:		
			Treatment		
			4: Type:		
			Treatment:		

Section 4 - Additional Health Conditions Your Doctor Has Diagnosed:

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Section 5 - Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date of incident if known:

Section 6 - Birth History:	
Vaginal or C-Section? (check) Vaginal □ C-Section □	Were you breast fed as an infant? (check) Yes □ No □

Section 7 - Please list any current Medications and/or Vitamins/Supplements you take and the dosage:		
Medication or Vitamin	**Dosage**	**Frequency**
Example: Vitamin C	500mg	1x/day

Section 8 – Diagnosis Codes - *To Be Filled Out by Doctor*